Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

FOUNDATION HEALTHCARE AFFILIATES OF
SAN ANTONIO
14000 N PORTLAND AVE SUITE 204
OKLAHOMA CITY OK 73134-4042

Respondent Name
INSURANCE CO OF THE STATE OF PA

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-12-2926-01

MFDR Date Received
MAY 21, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Low payment. Gallagher Bassett did not pay for the cost of the implants plus additional 10%. Additional Reimbursement should be $34,705.00. Implant Cost: $31,550.00...Ten Percent: $3,155.00"

Amount in Dispute: $34,705.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response for review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 7, 2011 Through June 10, 2011	Inpatient Hospital Surgical Services	$34,705.00	$29,960.23

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated July 29, 2011
   - 16 — (16) CLAIM/SERV LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION.
   - W1 — (W1) WORKERS' COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.
   - BL — TO AVOID DUPLICATE BILL DENIAL, FOR ALL RECON/ADJUSTMENTS/ADDITIONAL PYMNT REQUESTS, SUBMIT A COPY OF THIS EOR OR CLEAR NOTATION THAT A REC

   Explanation of benefits dated December 12, 2011
   - 16 — (16) CLAIM/SERV LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION.
   - W1 — (W1) WORKERS' COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.
   - BL — THIS BILL IS A RECONSIDERATION OF A PREVIOUSLY REVIEWED BILL. ALLOWANCE AMOUNTS DO NOT REFLECT PREVIOUS PAYMENTS

   Explanation of benefits dated January 2, 2012
   - 16 — (16) CLAIM/SERV LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION.
   - W1 — (W1) WORKERS' COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.
   - BL — THIS BILL IS A RECONSIDERATION OF A PREVIOUSLY REVIEWED BILL. ALLOWANCE AMOUNTS DO NOT REFLECT PREVIOUS PAYMENTS.

Issues

1. Were the disputed services subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011?
2. Which reimbursement calculation applies to the services in dispute?
3. What is the maximum allowable reimbursement for the services in dispute?
4. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:
   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
   (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables."

   No documentation was found to support the existence of a contractual agreement between the parties to this dispute; therefore the MAR can be established under §134.404(f).

2. §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 143 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."

   Review of the documentation finds that that the facility requested separate reimbursement for implantables; for that reason, the requirements of subsection (g) apply.

3. §134.404(g) states, in pertinent part, that "(g) Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission.
   (1) A facility or surgical implant provider billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual costs (net amount, exclusive of rebates and

discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge."

Review of the documentation found supports that the following items were certified as required by (g):

Itemized Statement Rev Code or Charge Code	Itemized Statement Description	Cost Invoice Description	# Units & Cost Per Unit	Cost Invoice Amount	***Per item*** Add-on (cost +10% or $1,000 whichever is less).
278	Screw	Screw 4.5	1 at $193.00 ea	$193.00	$212.30
278	Reversed Glenoid	Reversed Glenoid Sphere 0 D .36MM	1 at $3,523.00 ea	$3,523.00	$3,875.30
278	Humeral Stem	Aequalis Reversed Cemented Stem D.9MM	1 at $2,860.00 ea	$2,860.00	$3,146.00
278	Metaphysis 36MM	Aequalis Reversed Cemented Methaphysis D.36MM	1 at $2,251.00 ea	$2,251.00	$2,506.10
278	Lateral Insert	AEQ Reversed Lateral Insert D.36 x 9	1 at $1,064.00 ea	$1,064.00	$1,170.40
278	Plate Subacrom Suppt	Custom Acromial Support Plate	1 at $9,660.00 ea	$9,660.00	$10,626.00
278	Screws Subacrom Supp	Custom Sub Acromial Support Screws	1 at $2,930.00 ea	$2,930.00	$3,223.00
278	Support Subacromial	Custom Sub Acromial Support	1 at $8,630.00 ea	$8,630.00	$9,493.00
278	Screw	Screw 4.5 x40	1 at $193.00 ea	$193.00	$212.30
278	Cement Resitrictor	Cement Restrictor	1 at $246.00 ea	$246.00	$270.60

$31,550.00	$34,735.00
Total Supported Cost	**Sum of Per-Item Add-on**

The division finds that the facility supported separate reimbursement for these implantables, and that the cost invoices were certified as required. Therefore, the MAR is calculated according to §134.404(f)(1)(B).

4. §134.404(f)(1)(B) establishes MAR by multiplying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors (including outliers) by 108%, ***plus*** reimbursement for items appropriately certified under §134.404(g). The Medicare IPPS payment rates are found at http://www.cms.gov, and the sum of the per-item add-on for which separate reimbursement was requested are taken from the table above.

   - Documentation found supports that the DRG assigned to the services in dispute is DRG 484, and that the services were provided at Foundation Healthcare Affiliates of San Antonio. Consideration of the DRG, location of the services, and bill-specific information results in a total Medicare facility specific allowable amount of $10,256.46. This amount multiplied by 108% results in an allowable of $11,076.98.

- The total cost for implantables is $31,550.00. The sum of the per-billed-item add-ons exceeds the $2000 allowed by rule; for that reason, the total allowable amount for implantables is $31,550.00 plus $2,000, which equals $33,550.00.

Therefore, the total allowable reimbursement for the services in dispute is $11,076.98 plus $33,550.00, which equals $44,626.98. The respondent issued payment in the amount of $14,666.75. Based upon the documentation submitted, additional reimbursement in the amount of $29,960.23 is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $29,960.23 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		November 29, 2012
Signature	Medical Fee Dispute Resolution Officer	Date
		November 29, 2012
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.